STATE OF MONTANA
DEPARTMENT OF CORRECTIONS
COMMUNITY WORK PROGRAM REQUEST FORM

PROGRAM INFORMATION

Requesting Agency		Number of Offenders Needed	Request Date
☐ Internal ☐ External	☐ State Agency ☐ Non Profit ☐ School District ☐ City ☐ County Other: _____	_____	_____

Contact Person: _____ Telephone Number: _____

Offender(s) Name, DOC ID# and Living Location:

Program Description:

Location: (Provide sufficient detail for emergency assistance)

Payment Terms: _____ Program Work Hours: _____

Projected Start Date: _____ Projected Completion Date: _____

FACILITY INFORMATION

Facility/Program Name: _____ Region (If applicable): _____

Work Program Supervisor Name: _____ Telephone Number: _____

Note Agency Program Responsibilities:

REQUESTING AGENCY OR ORGANIZATION INFORMATION

Transportation Provided By Requesting Agency	Method of Transportation: (Indicate One)	Vehicle Capacity
☐ Yes ☐ No	☐ Van ☐ Pickup ☐ Bus ☐ Other: *(Specify)* _____	_____

Tools, Supplies and Safety Equipment to be used:

Provisions for food and water:

Name(s) of Supervisor(s) who will provide safety instructions and oversee work:

Provisions for access to restrooms *(Identify Type and Location)*

Identify additional assistance being provided by requesting agency:

Requesting Agency Program Supervisor Name: _____ Telephone Number: _____

ACCOMODATIONS PROVIDED BY MONTANA DEPARTMENT OF CORRECTIONS

(To be filled out jointly with Requesting Agency)

Size of Offender Work Force: _____ Number of Correctional Staff Assigned: _____

Special Needs *(i.e. clothing, equipment)* _____

Mobile Communications *(i.e., cellular phone, hand held radio):* _____

Food Service: _____

Vehicles: _____

Armory: _____

Other: _____

HEALTH AND SAFETY REVIEW

(Complete only if the administrator or Contract Placement Bureau Chief requests a safety and health review.)

I have evaluated the above referenced program , which has also been reviewed by certified personnel provided by the requesting entity. My decision regarding the program is as follows:

☐ Approved ☐ Disapproved _____

Investigations Bureau Chief, or Designee

PROGRAM RECOMMENDATION AND AUTHORIZATION

☐ Approved ☐ Denied

Reason for Denial *(i.e., staff resources, etc.)*

Signature: _____ Date: _____

Requesting Agency Representative

Signature: _____ Date: _____

Warden/Superintendent/Facility Administrator

Signature: _____ Date: _____

Contract Placement Bureau Chief *(if necessary)*

This form is filled out by the requesting party and submitted to staff designated to evaluate the offender work assignment.. This form must be attached to the Community Work Program Screening Form.

This agreement shall be effective upon signature and shall remain in effect until the program completion date or until such time as either party terminates said agreement.